454th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

MARCH 4, 2009

Chairman Young called the meeting to order at 8:54 a.m. Commissioners Joseph R. Antos, Ph.D., Raymond J. Brusca, J.D., Trudy R. Hall, M.D., Kevin J. Sexton, and Herbert S. Wong, Ph.D. were also present.

ITEM I
REVIEW OF THE MINUTES OF THE PUBLIC SESSION OF FEBRUARY 4, 2009

The Commission voted unanimously to approve the minutes of the February 4, 2009 Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Robert Murray, Executive Director, updated the Commission on the activity of the Payment Workgroup, the group that was assembled to review the options for the 2010 Update. Mr. Murray reported that although discussions on the three-year payment arrangement have been ongoing since November, only at the most recent meeting has there been very much progress. Both the hospital industry and the payers have now presented proposals. The payers presented a three year proposal with annual updates of 1.99%, while the hospitals proposed a one-year arrangement with an update of 3.75%. Mr. Murray stated that the parties with continue to meet, hoping, as it has in the past, to forge a compromise, or a near compromise recommendation. Mr. Murray stated that the intent is to present a draft recommendation at the April public meeting with a final recommendation ready for action at the May public meeting.

Mr. Murray summarized in detail the Report to the Governor entitled Review of Financial Assistance and Credit and Collection Activities of Maryland Hospitals. The Report is a response to the Governor's request for a thorough review of Maryland hospital financial and credit and collections policies. The Report is an interim report presenting background information concerning the provision of financial assistance and credit and collection activities by hospitals. It also presents an evaluation of those activities relative to previously developed voluntary standards and current national trends. In addition, the Report provides recommendations to address the problems and inconsistencies associated with the provision of financial assistance and credit and collection activities.

Mr. Murray stated that staff will assemble two task forces, one to review the Commission's UCC policy, and the other to develop guidelines for hospital credit and collection activities. Staff will report the results of the task forces' deliberations to the Governor and to the Commission in the fall.

Mr. Murray noted that former State Senator Rosalie Abrams, who was involved in crafting the original legislation creating the HSCRC, had recently passed away. Mr. Murray asked Hal Cohen, Ph.D., former Executive Director of the Commission, if he wished to say a few words about Mrs. Abrams.

Dr. Cohen expressed his great affection and respect for Mrs. Abrams. Dr. Cohen observed that Mrs. Abrams was not only the principal sponsor of the law that created the Commission, but was a friend of the Commission for many years. Dr. Cohen noted that Mrs. Abrams intended that the HSCRC be an independent Commission and felt that its independence was very important. She set the tone for that independence by recusing herself in the HSCRC's first contested rate setting case, with Sinai Hospital, although she was a member of that hospital's Board of Directors.

ITEM III
DOCKET STATUS CASES CLOSED

2013R – Memorial Hospital at Easton

ITEM IV
DOCKET STATUS CASES OPEN

Greater Baltimore Medical Center – 2015R

On January 23, 2009, the Greater Baltimore Medical Center filed an application requesting that the Hospital's Coronary Care Unit's (CCU) approved rate be collapsed into its Medical/Surgical Intensive Care Unit's (MIS) rate center, effective February 1, 2009. This request which involves the combining of two revenue centers, is revenue neutral and will not result in any additional revenue for the Hospital. The Hospital wishes to combine the two centers because their respective patients have similar staffing needs, and placement into a MIS or CCU is based on bed availability or staffing rather than on a diagnosis.

After reviewing the Hospital's application, staff recommended that the Hospital be allowed to collapse its CCU into its MIS rate effective February 1, 2009.

The Commission voted unanimously to approve staff's recommendation.

Johns Hopkins Health System – 2016A

Johns Hopkins Health System filed an application on February 2, 2009 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital for approval to continue to participate in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers. The requested approval is for a period of one year.

Based on historical favorable performance and projections, staff recommended that the Commission approve the Hospitals' application for a period of one year retroactive to January 1, 2009.

The Commission voted unanimously to approve staff's recommendation.

ITEM V
FINAL RECOMMENDATIONS ON MARYLAND HOSPITAL-ACQUIRED CONDITIONS (MHAC)

Mr. Murray stated that the focus of the presentation would be the questions posed, input received, and issues raised about the proposed MHAC initiative and staff's research and response thereto.

Diane Feeney, Associate Director-Quality Initiative, reviewed staff's activity over the last month. Ms. Feeney reported that two vetting sessions were conducted. Attending were hospital quality, case-mix, financial, and medical leaders. The purpose of the sessions was to vet the clinical, exclusions, and assignment logic for the potentially preventable conditions (PPCs) being proposed in the MHAC recommendation and engage in a dialogue concerning the clinical attributes of the methodology. Ms. Feeney noted that several clinicians provided extremely helpful input.

Ms. Feeney reported that another meeting was held in which hospitals were taught step-by-step how to calculate the payment decrement that would apply if MHAC was adopted and implemented.

Ms. Feeney stated that staff has prepared a list of the questions, feedback from the industry, issued raised, and staff's responses. Norbert Goldfield, M.D., 3M Health Information Systems (3M), reviewed in detail and presented staff's responses to: 1) the global suggestions for implementing the proposed MHACs; 2) the clinical concerns regarding specific proposed MHACs; and 3) the concerns raised about preventability and the "science" of the proposed MHACs. In addition, Ms. Feeney commented on concerns about the quality of administrative data. (Attachment A).

Dr. Goldfield stated that this feedback effort should be contrasted with that of Centers for

Medicare and Medicaid Services' (CMS) Hospital Acquired Conditions (HACs) where there are no exclusions and there were virtually no comments. Dr. Goldfield asserted that if complications are ever to be dramatically decreased in this country, it must be recognized that 100% standards are not appropriate. What is appropriate, however, is to develop and utilize global and disease related clinical exclusions, and also to recognize that the evidence-base for complications is not complete. As a result, 100% payment decrements should not be imposed, and for the more contentious PPCs, the payment decrement should be ultra-conservative. Dr. Goldfield noted that one of the benefits of a DRG-based model, as opposed to a regression model, is that feedback can be utilized in an ongoing effort to improve care.

Ms. Feeney asserted that Maryland's administrative data are better than most states primarily because of the implementation in Maryland of APR-DRGs in 2005 and the huge incentive to fully code provided by the Charge-per-Case payment system. Mr. Feeney presented a schedule that showed Maryland hospitals coded more secondary diagnoses per case than any other state.

Johns O'Brien, Deputy Director-Research and Methodology, addressed the operation and payment issues raised by the industry. Mr. O'Brien pointed out that unlike CMS' HACs payment decrements, the MHACs system does not affect payment for individual cases, but is applied to a hospital's overall allowed charges. The goal of MHACs is to create a hospital level incentive to increase quality by adjusting a hospital's overall allowable charges. The MHAC methodology is very conservative, since very few cases are subject to a revenue adjustment because of categorical and clinical exclusions. In addition, for those few cases identified, the revenue adjustment is only 90% of the increase in payment related to the PPC. The other 10% is intended to reflect the fact that even after exclusions; some complications are not 100% preventable. Mr. O'Brien noted that roughly 80% of the MHACs cases will have no payment decrement. Thus, the revenue impact is quite small, with the modifications proposed by staff today; the payment decrement is less than $5 million for all hospitals, approximately 0.06% of total allowable revenue.

Mr. O'Brien also stated that staff is recommending a "back-end" review process, i.e., the review of a sample of MHAC cases to ascertain whether the 90% payment decrement is appropriate, and when it is not appropriate to modify the decrement prospectively.

Mr. Murray stated that the MHAC initiative has strong support from the Maryland Health Care Commission (MHCC), the Department of Health and Mental Hygiene (DHMH), as well as the Maryland Office of Health Care Quality. CMS sent a letter stating that Maryland was lagging behind the nation and was the only state that had not implemented a system with payment decrements for PPCs. In addition, bills have been introduced in the legislature to address the issue of "never events," which are largely covered by the MHAC methodology; staff has had discussions legislators with who have emphasized the importance of addressing flaws in the payment system that reward hospitals for reduced quality.

Mr. Murray stated that not only was there support from governmental entities for this initiative, but there also seemed to be a desire on the part of many hospital clinicians who participated in the vetting sessions for the initiative, which provides them with monitoring and management

tools to help improve quality of care and reduce preventable complications and conditions.

Mr. Murray outlined staff's modified recommendations (Attachment B). The principal modifications to the draft recommendations included: 1) excluding PPC 63, Post-Operative Respiratory Failure with Tracheostomy; 2) adding additional clinical exclusions as a result of industry input for PPCs 39, 42, 57, 58, and 63 (for 3M's overall logic); and 3) conducting retrospective chart reviews to quantify false-positive occurrences relative to identified false-negative occurrences and to identify any additional unanticipated consequences or results which may lead to modifications of the MHAC initiative for the subsequent year. The unchanged recommendations include: 1) that payment decrements of 90% be applied to eligible MHAC cases; 2) that the initiative commence on April 1, 2009 with payment decrements being reflected in the following fiscal year; and 3) that the approved methodology also be applied to the rate year beginning July 1, 2009.

Mr. Murray noted that with the proposed modifications, removing PCC 63 and adding additional exclusions, the overall revenue decrement is reduced to approximately $3 million rather than the original estimate of $9.6 million. Mr. Murray emphasized that it is not about the money; the initiative is about providing the appropriate incentives in the system. MHACs, use a categorical model (a system of averaging), just as we do now with APR-DRGs to provide the right focus and incentive for the industry

Mr. Murray stated that staff strongly supports this initiative and believes it will be a positive enhancement to the system and will result in Maryland once again resuming a position of leadership in linking quality to payment.

Commissioner Sexton asked why PPCs 57 and 58 had much higher percentages of eligible cases than the other PPCs.

Dr. Goldfield explained that one reason was that there more cases in PPCs 57 and 58, the obstetrical (OB) PPCs.

Elizabeth McCullough of 3M added that the other reason that the OB PPCs have fewer clinical and global exclusions is because the patients are generally healthier.

Commissioner Hall asked Dr. Goldfield if he had any examples of how a hospital administration would make changes and handle physicians if these preventable conditions exist in a hospital.

Dr. Goldfield replied that whether identified as a result of a sentinel event or a high rate of events associated with an individual or hospital, the hospital should first examine each of the events in detail and then when the cause is identified, a variety of interventions are possible.

Commissioner Hall asked Mr. Murray if we are implementing this initiative because of

Medicare, why are we not using CMS's recommendations.

Mr. Murray replied that we are not implementing this initiative because of Medicare. We are implementing it because it provides the right incentives; it can be applied to all payers; and it can change behavior in a positive way for the industry as a whole. However, we are sensitive to the fact that we are lagging behind Medicare because of the waiver.

Dr. Goldfield stated that as a practicing clinician, he believes that the CMS HAC system implemented with no exclusions is clinically highly problematic. Dr. Goldfield observed that we are trying with MHACs to suggest a better way by identifying exclusions, and by creating a categorical model in which there will be ongoing feedback.

Carmela Coyle, President of the Maryland Hospital Association, stated that we all agree that our goal should be for Maryland to be at the head of the class in quality and patient safety, however, using the 3M methodology of withholding payment to hospitals is not the right approach. Ms. Coyle pointed out that there are three reasons why hospitals believe that this methodology is not the right approach: 1) there is no clear link between an error in care and the outcome for which payment would be withheld - - the 3M experts have just conceded that there is tension between when some of these complications are a routine part of care and when they could be preventable; 2) evidence-based prevention guidelines do not exist for most of the MHAC PPCs; and 3) the National Quality Forum's technical panel unanimous decided not to advance 35 of 3M's PPCs for endorsement because of the use of billing rather than clinical information, the lack of validation of the methodology, and lack of transparency since the methodology is proprietary.

According to Ms. Coyle, these 11 rare high-cost conditions, with no link to whether there was good or bad care delivered, have the potential to tell us very little about the quality of care in the State of Maryland. In addition, there is little overlap, only 2 conditions, between Medicare HACs and MHAC PPCs.

Ms. Coyle noted that using appropriate financial incentives to improve care is the right idea, but achieving results will take a lot of hard work. Although the 3M option is an interesting one, other options should be considered. The industry believes that the 3M methodology should not be linked to payment at this time. Since no other alternatives have been pursued, we really are not sure that this PPC methodology is the absolutely right approach.

Ms, Coyle encouraged the Commission to vote no to staff's recommendation. Ms. Coyle asserted that it would not be "no" to patient care quality improvement; rather, it should be "no" to linking hospital payments to the 3M methodology. The industry believes the Commission should vote no because: 1) the vetting process for PPCs should continue; 2) there are technical issues concerning payment decrements that have not been resolved; 3) the HSCRC does not have the expertise to perform the "back end" audits; and 4) with the recent significant modifications, the MHAC policy still is not clearly understood by the industry's clinicians.

Ms. Coyle urged the Commission to convene a group of the stake holders, as well State and

national quality experts, to look at what the principles for quality improvement in the State should be, what the options are, and then attempt to move to consensus on the right direction to pursue.

Ms. Coyle noted that while the industry suggests that the Commission vote no, if the Commission decides to pursue this methodology, and since there seems to be a fair amount of work to be done to validate the methodology, it should be pilot tested at a few hospitals at 3M's expense before making the policy state-wide.

Hal Cohen, representing CareFirst of Maryland and Kaiser Permanente, expressed strong support for staff's recommendation effective April 1st. Dr. Cohen stated that incentives are important. For example when the Guaranteed Inpatient Revenue system was implemented, hospitals claimed that they could not control physician practice. However, once the incentives were in place, practices changed, and the average length of stay for Medicare patients declined. And, although there is very little decrement involved, the payers believe that we are beginning with the right structure that recognizes that patients, payers, and the industry should have better incentives to reduce overall complication rates.

Barry Rosen, representing United Healthcare, endorsed staff's recommendation. Mr. Rosen stated that the real "back end" review is measuring whether complications go down or not. If this endeavor causes hospital complications to go down, that is success, not the $3 million payment decrement. Success is whether hospitals and physicians modify their behavior.

Scott Spier, M.D., Medical Director-Mercy Medical Center (Mercy), expressed support for Ms. Coyle's comments. Dr. Spier stated that physicians at Mercy were concerned that several of the MHAC complications can occur even with good medical care. According to Dr. Spier, the adoption of MHACs may cause unintended consequences of less appropriate care or more expensive care. Dr. Spier presented several examples of such situations involving surgical MHACs.

Robert Atlas, M.D., Chair of Obstetrics at Mercy, noted that third and fourth degree lacerations can be 100% prevented by physicians avoiding vaginal deliveries and performing Caesarean sections instead. The MHAC program may encourage Caesarean sections, and with increased caesarean sections come increased complications, morbidity, and cost. Dr. Atlas proposed that rather than implement the MHAC recommendations, the State's Perinatal Collaborative would be a better alternative for identifying approaches to decreasing lacerations that are avoidable.

Andrew Satin, M.D., Chair OB/GYN- Johns Hopkins Bayview Medical Center, stated that there were also several factors that can pose a greater risk for lacerations that are not in the control of physicians, e.g., size of the baby, size of the mother, baby in occiput posterior position (backward), history of lacerations, and prolonged labor. Dr. Satin expressed agreement with Dr. Atlas that the performance of more Caesarian sections and mediolateral episiotomies were not acceptable alternatives to vaginal deliveries that bring with them, in some cases, unavoidable lacerations.

Donovan Dietrick. M.D., Director OB/GYN Residency Program-Franklin Square Hospital, reported that since 1984, the number of OB/GYN residency programs had decreased from nine to four. Dr. Dietrick also stated that the MHAC program would have a detrimental effect on the remaining OB/GYN residency programs by encouraging Caesarean sections and super cervical hysterectomies, and thereby, resulting in graduates avoiding vaginal deliveries.

Phillip Buescher, M.D., Critical Care Medicine-Union Memorial Hospital, voiced concern about the process for determining the conditions that were included in the MHAC recommendations. Dr. Buescher stated that physicians will do what is right for the patient regardless of financial incentives. However, incentives should be put in place for physicians to do things the "right way" by paying for training and the education of physicians on the best clinical practices and techniques.

James Raver, M.D., Senior Vice President/Chief Medical Officer-Western Maryland Health System, noted that most, if not all, of the clinical measures in the MHAC list are areas of focus of the Maryland Patient Safety Center or are otherwise being addressed. Dr. Raver asserted that applying payment reductions in an already stressed environment will reduce access, and that inappropriate incentives may delay good follow-up care. Dr. Raver presented several examples illustrating the difficulty of telling distinguishing between preventable and non-preventable complications. Dr. Raver stated that while hospitals have accepted the CMS list of hospital acquired conditions, there is concern about the level of preventability for the proposed MHACs which are not on the CMS list.

Commissioner Wong made a motion to modify staff's the recommendation. The Commissioner stated that he appreciated the work that staff, the industry, and others to get this proposal closer to something that is acceptable to everyone. Commissioner Wong observed: 1) that if we wait for scientific evidence that tells us what to do, we will be waiting a long time since there is very little research being done in this field; 2) that chart review as an alternative is not practical; and 3) that Maryland is in a unique position offer an alternative to CMS HACs . As to concerns about the use of administrative data, Commissioner Wong stated that with the addition of the POA indicator, Maryland's data are among the best in the nation. However, Commissioner Wong observed that the two greatest concerns raised were that the 3M software produces false positives, i.e., complications that seem to be preventable, but on further examination are not, and benchmarks, i.e., the hospital and the physicians have done everything right, but the complication still occurs. However, the recommended payment proposal calls for a decrement of 90% of the increment between what should have been paid and what was paid. It has a built-in 10% buffer for what cannot be controlled; whether there are false positives in the software or benchmarks, 10% of the decrement is not assessed.

Commissioner Wong made the following motion: 1) that the decrement rate be lowered from 90% to 85%; 2) that the retrospective chart review be used to determine whether the decrement rate is appropriate; and 3) that implementation of the policy be delayed until July 1, 2009 to allow staff and industry to work out the details of the policy and to consider whether or not other

conditions should be added to or deleted from the current list of PPCs.

Commissioner Antos seconded Commissioner Wong's motion. Commission Antos suggested that perhaps staff could monitor the benchmarks over the course of the year to ascertain whether it would be appropriate for some MHACs, in particular the obstetric PPCs, to have a more generous decrement rate.

Commissioner Lowthers expressed support for Commissioner Wong's motion; however, he expressed concern over going too slowly. Rather than engage in academic discussions, Commissioner Lowthers urged the Commission to move quickly and aggressively in this area.

Commissioner Sexton stated that we are searching to find where the benchmark is and how do you move it. Commissioner Sexton contended that you do that by sharing knowledge and applying incentives that are both positive and negative. Commissioner Sexton asserted that the proposed methodology does not measure up on those points. Commissioner Sexton proposed that rather than do chart review with the attending issue of blame, that we implement something along the traditional DRG pathway, since DRGS already provide a powerful incentive not to have problems. If you have outlier cases you usually lose money. We should explore a methodology that, for at least some of the MHACs, combines PPC up-coding cases with the other cases in the baseline to create a rate. Hospitals would be paid at that rate and could not up code to increase payment. The benefit would be that we have not blamed anyone, but we have set a normative standard with the incentive to work on ways to have fewer complications. It would reward hospitals that improve and penalize those that do worse. Commissioner Sexton urged the Commission to consider this alternative during the period before the implementation of the proposed policy.

Mr. Murray stated that penalties and rewards are implicit because of the zero-sum nature of our system. The intent of the $3 million decrement is that it generates discussion and interaction at the hospital level among administrators, financial managers, clinicians, and coders about what could be done, and what processes could be put in place to increase quality.

Commissioner Sexton stated that the if the impact was more immediate, more obvious, and more direct, more discussion would be generated about ways to increase quality.

Commissioner Hall stated that she agreed with the clinicians who spoke today that they do not believe that hospital administrations and these processes can actually make them do a better job. In addition, Commissioner Hall expressed strong concern about the inclusion of the maternal fetal MHACs and suggested that the MHACs associated with obstetrics be removed from the proposed policy.

Commissioner Brusca urged the Commission to move now and not delay. As we have done successfully in the past, we can make corrections to the policy based on experience.

Commissioner Antos stated that Commissioner Sexton's methodological alternative should be

considered if it is feasible; not to do so would be wrong. However, there should be no delay in implementation of a policy beyond July 1, 2009.

Mr. Murray stated that at this late date, it is not feasible to address an alternative using another set of indicators in two months after working on this methodology for many months. Staff believes that this is the first logical, step and staff remains very receptive to additional steps to refine and expand the methodology.

Commissioner Hall asked whether there would be an appeals process.

Mr. Murray stated that since the impact on payment of the policy is on an overall basis, it is appropriate that we have a back end review that looks at the overall impact of the policy and makes modifications on a prospective basis.

The Commission approved staff's recommendation with Commissioner Wong's modifications by a vote of 5 to 2, Commissioners Hall and Sexton opposing the motion.

ITEM VI
FINAL RECOMMENDATIONS FOR REVISIONS TO THE REASONABLENESS OF CHARGES (ROC) METHODOLOGY

Mr. O'Brien summarized the final recommendation for revisions to the ROC methodology. Mr. O'Brien noted that there were only three changes from the draft recommendation presented at the February public meeting. They are as follows: 1) staff accepted the industry's proposal that scaling of the FY 2010 Update apply to the top and bottom quartiles; 2) at the suggestion of the payers, high priority will be given to how capital is handled in the ROC, and whether partial rate review for capital are still necessary; and 3) that a direct strip of property and sales tax for the only for-profit hospital in the State be made in the ROC.

Mr. O'Brien reported that staff will meet with industry and payer representatives in the next month to discuss a technical issue as to how to apply the adjustments for Indirect Medical Education (IME) and Disproportionate Share (DHS). Mr. O'Brien stated that this issue does not change staff's recommendation or the policy; however, it does impact on a hospital's position on the ROC.

Mr. O'Brien announced that staff will report the resolution of the technical issue and will release the ROC calculation at the April 15th public meeting.

Dr. Cohen urged approval of staff's recommendation. Dr. Cohen also asked that staff look at two technical issues: 1) whether DSH should be applied as a difference from the state-wide mean, or whether it should be applied on actual costs, analogous to a strip; and 2) whether a state-wide peer group excluding academic medical centers (AMCs) and a national peer group for AMCs

should replace the current peer groups.

The Commission voted unanimously to approve staff's recommendation

ITEM VII
LEGISLATIVE REPORT

Steve Ports, Principal Deputy Director-Policy and Operations, reported that CMS informed the HSCRC that there is approximately $5.3 million available to Maryland hospitals in a federal EMTALA program, which provides reimbursement to hospitals and physicians for emergency medical care provided to undocumented aliens. According to CMS, no Maryland hospitals have taken advantage of the program. Staff intends to investigate why Maryland hospitals have not participated in the program and to find a way to encourage them to do so.

Ms. Traci Phillips, representing MHA, stated that it was MHA's belief that the program provided $5 million over 4 years and that approximately $650,000 would be available before the program ends, March 31, 2009. Ms. Phillips stated that MHA had been informed that after the program ends the funds would no longer be available for Maryland hospitals.

Mr. Ports stated that it was staff's understanding that the funds would be available until expended; however, staff would contact CMS to clarify whether or not the funds were still available.

Mr. Ports presented an update on legislation of interest to the HSCRC (attachment D). The most significant health care legislation is HB 1069/SB 776 Financial Assistance and Debt Collection Policies, which mandates a minimal hospital financial assistance policy of 150% of the Federal Poverty Level (FPL) and requires hospitals to: 1) include an information sheet with hospital bills and, upon request, include certain financial information; 2) make hospital staff available to assist patients and their families in understanding the hospital bills, and how to apply for other health care programs; and 3) submit to the HSCRC their policy on the collection of debts owed by patients. In addition, it requires the HSCRC to: 1) establish uniform requirements for the financial assistance information sheet; 2) review the implementation of and compliance relative to the information sheet and hospital collection policies; and 3) establish work groups to consider further changes necessary relative to hospital financial assistance and debt collection policies and for the HSCRC to review its uncompensated care policy to see if incentives can be created to provide more free or reduced-price care to the poor.

Mr. Ports stated that the HSCRC supports the legislation with following amendments: 1) that the minimal financial assistance be increased to 200% of the FPL; 2) that the issue prohibiting liens on primary residences be studied; and 3) that the rate of interest on late payment of hospital bills remain under HSCRC regulation.

Other bills of interest include: 1) SB435/HB758 - Never Events, which would require hospitals

to report "never events" to the CMS and disallows payment for these cases from Medicare and Medicaid if the hospital is responsible for the "never event." HSCRC supports the concept but prefers the MHAC approach under HSCRC's current authority; 2) SB 231/HB 487 – Annual Reports of Compensation which, would require hospitals to report to the HSCRC the annual compensation of its officers and expenditures for lobbyists; and 3) the Budget Reconciliation and Financing Act, which would reduce hospital rates for averted bad debt resulting from Medicaid expansion from 25% to 10%, and require certain Medicaid-eligible beneficiaries of the MHIP program to enroll in Medicaid in order to access federal matching funds.

Mr. Ports also announced that a Prince George's Hospital Authority bill was introduced. The bill would extend the time for the bidding process, allow the Maryland Health Care Commission to grant exemptions to the Certificate of Need process to facilitate agreements, and allow the assets to be transferred separately rather than as a single unit, when deemed appropriate by the Authority.

ITEM VIII
HEARING AND MEETING SCHEDULE

April 15, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room
May 6, 2009	Time to be determined, 4160 Patterson Avenue, HSCRC Conference Room

There being no further business, the meeting was adjourned at 11:50 a.m.